

# APPLICATION FOR REGISTRATION AS AN AGENCY-APPROVED REHABILITATION FACILITY

Michigan Department of Labor & Economic Growth  
Workers' Compensation Agency  
P.O. Box 30016, Lansing, MI 48909

Name of Entity			
Address	City	State	Zip
Phone Number w/Area Code	E-mail Address		
Name of Chief Executive Officer	Title		
<p>Check all that apply:</p> <div style="display: flex; justify-content: space-around; margin-top: 10px;"> <span>Public Corporation</span> <span>Private Date of Incorporation: _____</span> <span>Profit</span> <span>Non-profit State: _____</span> </div> <p style="margin-top: 10px;">Private company/not incorporated</p>			
Social Security Number, if individual		Federal Employer Identification Number (FEIN)	
<p>1. If currently licensed, certified, approved or accredited by any public or private body, indicate name, address, licensure number if appropriate, and expiration dates. (If more than one certification or accreditation, list them all.)</p>			
<p>2. List names, number and type of professional staff (attach résumés).</p>			
<p>3. Complete the <b>Service and Fee Schedule</b> section of this application indicating services you provide, units of service, and cost of each designated service.</p>			
<p>4. Attach letters of recommendation from three (3) Michigan carriers and/or employers who are currently referring, or in the past have referred, cases for your services.</p>			
<p>5. State what experience or qualifications you have in workers' compensation rehabilitation.</p>			
<p>6. Attach any supportive data, list of activities or other such information that you feel may assist in evaluating your application.</p>			

## SERVICE AND FEE SCHEDULE

I am/We are qualified to provide the following services for workers' compensation rehabilitation (check each service you are qualified to provide or submit a copy of your company's fee schedule):

SERVICE		UNIT OF SERVICE	FEE
<b>Physical Rehabilitation:</b>			
a.	Evaluation		
b.	Physician		
c.	Physical Therapy		
d.	Occupational Therapy		
e.	Psycho-social		
f.	Speech & Audiology		
g.	Prosthetics & Orthotics		
h.	Education		
i.	Pain Management		
j.	Counseling		
k.	Other (Specify)		
<b>Vocational Rehabilitation:</b>			
a.	Job Analysis		
b.	Job Modification		
c.	Analysis of Transferable Skills		
d.	Labor Market Survey		
e.	Vocational Testing		
f.	Work Evaluation		
g.	Work Adjustment		
h.	Job Seeking Skills Training		
i.	Job Development		
j.	Job Placement		
k.	Follow-Up		
l.	On-the-Job Training		
m.	Counseling		
n.	Other (Specify)		

I authorize the Department of Labor & Economic Growth, Workers' Compensation Agency, to make any investigation of the application and supporting documents. I understand that any omission or misrepresentation may result in rejection or revocation of approval. I hereby agree to be bound by all rules, regulations, policies and procedures as established by the director, and realize that violations may result in revocation of approval. I also agree to notify the Workers' Compensation Agency of any violations or possible violations.

\_\_\_\_\_  
Print or Type Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Subscribed and sworn to before me this

\_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

Notary Public \_\_\_\_\_

\_\_\_\_\_ County, Michigan.

My Commission Expires: \_\_\_\_\_.